

Medical Assistance Administration



Vision Care

Billing Instructions

September 2000

About this publication

This publication supersedes MAA's Optometrist Billing Instructions, dated March 1998 Optician Billing Instructions, dated November 1991 and the following issuances:

Numbered Memoranda:

98-08 MAA, 00-20 MAA, 00-23 MAA

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Related publication

MAA encourages Ophthalmologists and Opticians to also refer to the Physicians-Related Services (RBRVS) billing instructions, current version for further billing codes.

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Received too many billing instructions?

Too few?

Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)].

Applying for a provider #

Call the toll-free line:

(800) 562-6188, Select Option 1

or call one of the following numbers:

(360) 725-1026

(360) 725-1032

(360) 725-1033

Where do I send my claims?

Hard Copy Claims:

Division of Program Support

PO Box 9248

Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:

Division of Program Support

Claims Control

PO Box 45560

Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:

<http://maa.dshs.wa.gov> or write/call:

Provider Relations Unit

PO Box 45562

Olympia WA 98504-5562

(800) 562-6188

Who do I call about Electronic Billing?

Electronic Billing Unit

(360) 725-1267

Where do I send completed prescriptions and/or purchase orders for sample kits, eyeglass frames, lenses, and contact lenses?

Airway Optical

11919 West Sprague Avenue

PO Box 1959

Airway Heights, WA 99001-1959

Customer Service: 1-888-606-7788

Fax: 1-888-606-7789

Where do I call or write if I have questions regarding...

Policy, payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit

(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Division of Client Support

Coordination of Benefits Section

(800) 562-6136

Limitation Extension

Division of Health Services Quality Support

Quality Fee for Service Section

Limitation Extension

PO Box 45506

Olympia, WA 98504-5506

Telephone: (360) 725-1583

Fax: (360) 586-2262

Definitions

This section defines terms and acronyms used in this booklet.

Authorization - Official approval for department action.

Authorization Number - A nine-digit number, assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Blind - Visual acuity for distant vision of 20/200 or less in the better eye with best correction; or a limitation of the client's visual field (widest diameter) subtending an angle of less than 20 degrees from central.

Client - An applicant for, or recipient of, DSHS medical care programs.
(WAC 388-500-0005)

Department - The state Department of Social and Health Services [DSHS].
(WAC 388-500-0005)

Expedited Prior Authorization – A process designed by MAA to eliminate the need for written prior authorization (see definition of “prior authorization”). MAA establishes authorization criteria and identifies this criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Expedited Prior Authorization Number - A 9-digit number created by the provider to bill MAA for diagnoses, procedures and services that meet the MAA's EPA criteria.

- The first six digits of the EPA number must be **870000**.
- The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Limitation Extension – Written or expedited prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in the billing instructions.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
(WAC 388-538-050)

The Washington state managed care program is called “Healthy Options.”

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance Identification (MAID) card – The forms DSHS uses to identify clients in medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.
(WAC 388-500-0005)

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Management (PCCM) The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services.
(WAC 388-538-050)

Primary Care Provider (PCP) – A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.
(WAC 388-538-050)

Prior Authorization – Written MAA approval for certain medical services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extensions are forms of prior authorization.

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance And Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Stable Visual Condition – A client's eye/vision condition has recovered from any acute disease or injury to the extent that eyeglasses or contact lenses are appropriate and that any prescription for refractive lenses is likely to be sufficient for one year or more.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- 1) The usual and customary charge that you bill the general public for the same services; or
- 2) If the general public is not served, the rate normally offered to other contractors for the same services.

Visual Field Exams or Testing – A process to determine defects in the field of vision and tests of the function of the retina, optic nerve and optic pathways. The process may include simple confrontation (not reimbursable by MAA) to increasingly complex studies with sophisticated equipment.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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Provider Eligibility/Responsibility

Who is eligible to provide vision care services to MAA clients?


The following professionals are eligible to enroll/contract with the Medical Assistance Administration (MAA) to provide vision care services within their scope of practice to eligible MAA clients:

- Ophthalmologists (MD or DO);
- Optometrists; and
- Opticians.

Provider Responsibility

Enrolled/contracted eye care providers must:

- Provide only those services that are within the scope of the prescribing provider's license; and
- Obtain all hardware and contact lenses from MAA's contract provider.

 **Note:** Please check accuracy of all prescriptions and order forms submitted to MAA's contract provider.

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Client Eligibility

Who is eligible for vision care services?

Clients with one of the following identifiers on their Medical Assistance Identification (MAID) cards are eligible for vision care services:

<u>MAID Identifier</u>	<u>Medical Program</u>
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program – Children’s Health Insurance Program
CNP - Children’s Health	Categorically Needy Program – Children’s Health
GA-U - No Out of State Care	General Assistance-Unemployable - No Out of State Care
General Assistance – No Out of State Care	ADATSA
LCP – MNP	Limited Casualty Program - Medically Needy Program

Limited Coverage:

Clients with the following identifiers on their Medical Assistance Identification (MAID) cards are restricted to services associated with an emergency medical condition (payable in a hospital setting only). Office and ambulatory surgical center services are not payable when the clients have the following identifiers on their MAID cards. In certain situations, a client is put on the Medically Indigent Program (MIP) for the sole purpose of cataract surgery or retinal detachment.

<u>MAID Identifier</u>	<u>Medical Program</u>
CNP – Emergency Medical Only	Categorically Needy Program – Emergency Medical Only
Emergency Hospital and Ambulance Only	Medically Indigent Program
LCP-MNP Emergency Medical Only	Limited Casualty Program – Medically Needy Program (Emergency Medical Only)
QMB-Medicare Only	Qualified Medicare Beneficiary (Medicare Premiums/Copays Only)

Are clients enrolled in a Healthy Options managed care plan eligible for vision care services?

Clients with an identifier in the HMO column on their MAID cards are enrolled in one of MAA's managed care plans. **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's Healthy Options managed care plan. Clients can contact their plans by calling the telephone number listed on their MAID card.

Frames, lenses, and contact lenses must be ordered from MAA's contractor. These items are covered fee-for-service. (See information on ordering, page J.2.) Eligibility, coverage, and billing guidelines found in this billing instruction apply to Healthy Options clients.

Primary Care Case Management (PCCM) clients will have the PCCM identifier in the HMO column on their MAID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form. (See the *Billing* section for further information.)



Note: For further information on Healthy Options, see MAA's website:
<http://maa.dshs.wa.gov/HealthyOptions>.

Eye Care Services

Eye Examinations and Refractions – billable by Optometrists and Ophthalmologists.

Fitting Fees – billable by Opticians/Optometrists/Ophthalmologists.

What services are covered and how often?

Eye examinations, refractions, and fitting fees

MAA covers medically necessary eye examinations, refractions, eyeglasses (frames and lenses), and fitting fees as follows:		
Asymptomatic clients	Adults (21 years or older)	Once every 24 months
Asymptomatic clients	Children (20 years or younger)	Once every 12 months
Clients identified by MAA as developmentally disabled (<i>MAID card will have an “X” in the DD Client column.</i>)	Adults and Children	Once every 12 months

(The provider must document the diagnosis and/or treatment in the client’s record to justify the frequency of examinations and other services.) MAA limits eyeglass reimbursement to specific contract frames and contract lenses. MAA pays a fitting fee for frames, lenses, and contact lenses provided by, or obtained through, the contractor (see Section J: Where and How Do I Order?). If the client has a serviceable frame that meets MAA’s size and style requirements, MAA will pay for a fitting fee.

Under what circumstances would the above previous limits NOT apply?

1. **Change in prescription (spherical equivalent of ± 1 diopter):** The 24-month limitation does not apply to a change in prescription spherical equivalent of ± 1 diopter. To justify this diopter change, you must use state-assigned diagnosis code 367.99.
2. **Clients in nursing facilities:** MAA reimburses for services provided to clients in a nursing facility. Services must be ordered by the client's attending physician and documented in the facility's client care plan. The need for services must be clearly documented in the facility's client medical record, and the corresponding services provided must be documented in the medical record at the time the services are delivered.
3. **Eye examinations relating to medical conditions:** MAA reimburses for examinations relating to medical conditions (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.) as often as medically necessary.
4. **Eye exam due to lost or broken glasses**

MAA covers eye exams within two years of the last exam when no medical indication exists and **both** of the following are documented in the client's record:

- The glasses or contacts are broken or lost; and
- The last exam was 18 months ago or longer.



Note: For billing, see Section I – Authorization.

5. **Visual field exams (CPT codes 92081, 92082, and 92083)** MAA covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. MAA does not reimburse visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for MAA clients. Your records must support medical necessity for the visual field tests.

Documentation in the record must show:

- ✓ The extent of the testing;
- ✓ Why the testing was reasonable and necessary for the client; and
- ✓ The medical basis for the frequency of testing.

Program Limitations

Special Ophthalmological Services - Bilateral Indicator: MAA considers special ophthalmological services to be bilateral if they are routinely provided on both eyes. For MAA purposes, this includes CPT code 92015, determination of refractive state. Do not use bilateral modifier 50 or modifiers LT and RT for these services since payment is based on a bilateral procedure.

Reporting Diagnoses: MAA requires a diagnosis for a medical condition. The diagnosis assigned to a procedure is the first-level justification for that procedure. Please note: Use V72.0 (Examination of eyes and vision) only for eye exams in which no problems were found.

E/M Procedures: Use Evaluation and Management (E/M) codes for eye examinations for a medical problem, not for the prescription of eyeglasses or contact lenses. ICD-9-CM diagnosis codes 367.0-367.9 and "V" codes are not appropriate when billing E/M services.

Modifier 55 for Optometrists: When billing follow-up for surgery procedures, use the surgery code and modifier 55 to bill MAA.

Billing: Since payment for the surgical procedure codes with modifier 55 is a one-time payment covering the postoperative period, MAA will deny any claims submitted for related services provided during that period. You must bill any other specific problems treated during that period using modifier 25.

Payment: The amount allowed for postoperative management will be based on the Resource Based Relative Value Scale (RBRVS) Fee Schedule. (Obtain a copy at <http://maa.dshs.wa.gov> under Billing Instructions link or call 1-800-562-6188.)

What services are not covered?

MAA does not cover:

- ✓ Evaluation and Management (E/M) codes and an eye exam on the same day;
- ✓ Nursing home visits and an eye exam on the same day;
- ✓ Any services with prescriptions over two years old;
- ✓ Missed appointments;
- ✓ Orthoptics and visual training therapy; or
- ✓ Group vision screening for eyeglasses (except for EPSDT services).

Billing

Refer to the Physician-Related Services (RBRVS) billing instruction/fee schedule for a complete listing of CPT codes and maximum allowables. (Go to <http://maa.dshs.wa.gov> under Billing Instructions link, or call the Provider Inquiry Unit at 1-800-562-6188 to request a hard copy through the mail.)

Eyeglasses

(See previous section for coverage details on eye examinations, refractions, and fitting fees.)

When does MAA cover eyeglasses (frames and/or lenses)?

MAA covers eyeglasses (frames and/or lenses) when the:

- Client's condition that requires correction in one or both eyes is stable;
- Prescription is less than two years old; and
- Minimum correction need is documented and meets one of the following:
 - ✓ Sphere power equal to, or greater than, plus or minus 0.50 diopters; or
 - ✓ Astigmatism power equal to, or greater than, plus or minus 0.50 diopters.

MAA limits eyeglass reimbursement to specific contract frames, lenses, and contact lenses. MAA pays a fitting fee **only** for frames, lenses, and contact lenses provided by, or obtained through MAA's contractor (see Section J: Where and How Do I Order?). However, if the client owns serviceable frames that meet MAA's size and style requirements, MAA will pay for a fitting fee.

How often does MAA cover eyeglasses?

MAA limits eyeglass reimbursement to specific contract frames, lenses, and contact lenses. Lenses are allowed for an existing frame (see shaded box below). A fitting fee is paid **only** for frames, lenses, and contact lenses provided by, or obtained through, the contractor. However, if the client owns serviceable frames that meet MAA's size and style requirements, MAA will pay for a fitting fee.

Requests for lenses only

MAA covers requests for lenses only when:

- The eyeglass frames are serviceable,* and
- The size and style of the required len(s) and/or frame type meets MAA requirements.

***Note:** Due to time, exposure to elements, and concealed damage working with these frames can be unpredictable. MAA's contractor does not accept responsibility for these frames.

Eyeglasses (lenses/frames)

MAA covers eyeglasses as follows:		
Clients	Adults (21 years or older)	Once every 24 months
Clients	Children (20 years or younger)	Once every 12 months
Clients identified by MAA as developmentally disabled (<i>MAID card will have an "X" in the DD Client column.</i>)	Adults and Children	Once every 12 months
Clients who have been unable to adjust to contact lenses after 30 days.	Adults and Children	As medically necessary (<i>The provider must document the client's inability to adjust and the client must return the eyeglasses to the provider.</i>)

Replacements

MAA covers replacement eyeglasses (lenses/frames) that have been broken or lost as follows:	
Clients 21 years and older	Requires MAA's expedited prior authorization (see Section I)
Clients 20 years and younger	Does not require MAA's prior authorization
Clients identified by MAA as developmentally disabled, regardless of age (<i>MAID card will have an "X" in the DD Client column.</i>)	Does not require MAA's prior authorization

Repairs (Upon expiration of the one-year warranty period by contractor) Billable by Ophthalmologists/Optometrists/Opticians)

Eyeglass repair includes replacement of frame front, temple(s), soldering, and/or hinge repair. MAA covers incidental repairs to a client's eyeglass frames when both of the following apply:

- The repair or adjustment is not typically provided to the public at no cost (such as tightening and/or straightening the frame, or replacing a hinge screw); and
- The cost of the repair does not exceed MAA's cost for replacement frames.

Eyeglass repair parts and materials may be ordered from the state contractor or any manufacturer of optical devices and will be paid up to MAA's maximum allowable fee for repair.

Billing for Repairs

Please use the following state-unique procedure code when billing MAA for an eyeglass repair:

State-Unique Procedure Code	Description	Maximum Allowable Fee Non-Facility/Facility Setting
9274M	Materials for eyeglass repair (specify materials billed)	\$14.64

Note: Use state-unique procedure code 9274M for repairs only when materials are being replaced. Materials must be documented with an invoice or like statement from the manufacturer or the contractor showing the client's name. If the needed materials are in stock and a charge is normally made to the public for these materials, the repair fee requirement would be satisfied providing that the use of the specific part is documented in the client's record.

Additional Options

Nonallergenic frames

If the client has a medically diagnosed allergy to metal, MAA covers coating the frames to make them non-allergenic.

Upgrades

MAA **does not** authorize clients to upgrade eyeglass frames and pay only the upgrade costs in order to avoid MAA's contract limitations.

Back-up eyeglasses

MAA covers back-up eyeglasses when contact lenses are the client's primary visual correction aid (see Contact Lenses section, page G.1) as follows:

Clients 20 years or younger	One pair every two years
Clients 21 years and older	One pair every six years
Clients – Regardless of Age	When MAA agrees in advance to the medical necessity.

Durable or Flexible Frames

MAA covers pre-approved special frames called “durable frames and flexible frames” through MAA’s contracted supplier when a client:

- Is diagnosed with a seizure disorder that results in frequent falls; or
- Has a medical history that has resulted in two or more broken eyeglass frames in a 12-month period.



Note: For billing, see Section I – Authorization.

What is not covered?

MAA does **not cover** the following eyeglasses:

- ✓ Eyeglasses upgraded at private expense to avoid MAA’s contract limitations;
- ✓ Two pairs of glasses in lieu of multifocals; or
- ✓ Non-medically necessary glasses.

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Eyeglass Lenses

Billable by Optometrists/Ophthalmologists.

What is covered?

MAA covers the following eyeglass lenses and lens treatments:

Eyeglass Lenses and Lens Treatment (through Contractor)

1. One pair of:

- Single vision;
- Round or flat top D-style bifocals; and
- Trifocals (25 mm or 28mm);

2. Glass Lenses (in clear only)

In eye-size 54 millimeters or smaller for all contract frames or noncontract serviceable* frames owned by MAA clients.

<p>*Note: Due to time, exposure to elements, and concealed damage working with noncontract frames owned by MAA clients can be unpredictable. MAA's contractor does not accept responsibility for these frames.</p>

3. Plastic Lenses (in clear only)

In all sizes to fit all contract frames or noncontract frames owned by MAA clients. Plastic lenses can be up to any prescription power. (For information on tinted lenses, see next page.)

4. Treating Plastic Lenses for Scratch Resistance

MAA covers treating plastic lenses for scratch resistance only when the client:

- Is 20 years of age or younger; or
- Is determined by MAA to be developmentally disabled (check the client's MAID card for an "X" in the DD column).

Requests for lenses only

MAA covers requests for lenses only when:

- The eyeglass frames are serviceable,* and
- The size and style of the required lense(s) and/or frame type meets MAA requirements.

***Note:** Due to time, exposure to elements, and concealed damage working with noncontract frames frames owned by MAA clients can be unpredictable. MAA's contractor does not accept responsibility for these frames.

Which eyeglass lenses and lens treatment require medical justification?

Medical justification and/or ICD-9-CM diagnosis code(s) must be clearly written on the order form to the contractor for the following lenses:

1. **Bifocal Lenses Replaced with Single Vision Lenses – or - Trifocal Lenses Replaced with Bifocal Lenses or Single Vision Lenses**

Due to a client's normal inability to adjust quickly to lens changes, MAA requires **all of the following** before allowing lenses to be replaced as specified above:

- A client must attempt to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustment; and
- The bifocal or trifocal lenses are returned to the provider.

A statement from the attending physician must be in the client's record indicating that the treatable condition(s) is stable before new lenses may be allowed.

2. High Index Lenses for Refractive Change

MAA covers high index lenses when the client requires a refractive correction of plus or minus 8 diopters or greater.



Note: You must bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.

3. Executive Bifocals or Trifocals (plastic only)

MAA covers plastic executive bifocals or trifocals only for clients who are diagnosed with:

- Accommodative esotropia (client demonstrates that one or both eyes tend to turn in under fatigue or stress); or
- Strabismus.



Note: You must bill using MAA's Expedited Prior Authorization (EPA) process along with ICD-9-CM diagnosis codes 378.0-378.9. See Section I.

4. Tinting of Plastic Lenses

MAA covers the tinting of plastic lenses only when:

- The client's medical need is diagnosed and documented as a chronic eye condition (expected to last longer than 3 months) causing photophobia; and
- The tinting is done by MAA's contracted lens supplier.

When billing MAA, use the appropriate ICD-9-CM code from the following list:

Medical Problems	ICD-9-CM Diagnosis Codes
Chronic iritis, iridocyclitis (uveitis)	364.10-364.11 364.50-364.59
Optic atrophy and/or optic neuritis causing photophobia	377.1-377.6
Chronic corneal keratitis	370.0-370.07
Glaucoma	365-365.9
Rare photo-induced epilepsy conditions	345.0-345.9
Migraine disorder	346.0 and 346.2
Diabetic retinopathy	362.01-362.02

5. Glass Photochromatic Lenses (includes photogray lenses)

Plastic photochromatic lenses are not allowed.

MAA covers glass photochromatic lenses only when the client's medical need is diagnosed and documented as related to either of the following:

- Ocular albinism; or
- Blindness.

Medical Problems	ICD-9-CM Diagnosis Codes
Albinism	270.2
Retinitis pigmentosa	362.74
Optic atrophy and/or optic neuritis	377.1-377.6

6. Polycarbonate Lenses

MAA covers polycarbonate lenses when a client:

- Is blind in one eye (see definition for “blind”) and needs protection for the other eye, regardless of whether a vision correction is required; or
- Is 20 years of age or younger and diagnosed with strabismus or amblyopia; or
- Is identified by MAA as developmentally disabled, regardless of the client's age.

Medical Problems	ICD-9-CM Diagnosis Codes
Persons who are blind in one eye and need protection for the other eye.	369.6-369.69 369.71-369.73
Infants/toddlers with motor ataxia	331.89 781.2 334.0-334.9 781.3
Amblyopia	368.01-368.03
Young children with strabismus	378-378.9

Replacements

- MAA covers lens replacement for lost, broken, or stolen lenses (outside the 90-day warranty period provided by the contractor) as follows:

Clients 21 years and older	Requires MAA's EPA Process (see Section I)
Clients 20 years and younger	Does not require MAA's prior authorization
Clients identified by MAA as developmentally disabled, regardless of age (<i>MAID card will have an "X" in the DD Client column.</i>)	Does not require MAA's prior authorization

- MAA covers lens replacements through the expedited prior authorization (EPA) process without regard to time limits when all of the following apply:
 - ✓ One of the following caused the vision change:
 - Eye surgery;
 - The effect(s) of prescribed medication; or
 - One or more diseases;
 - ✓ Both the eye condition and the treatment have stabilized; and
 - ✓ The lens correction has at least one diopter difference between the old and new prescriptions. (A change of at least one diopter does not apply to separate pairs of eyeglasses for distance and reading, or for two pair of eyeglasses in place of multifocals.)



Note: For billing, see Section I – Authorization.

What is not covered?

MAA does **not cover** the following eyeglass lenses:

- ✓ High index lenses with correction less than 8 diopters;
- ✓ Second or replacement lenses during pregnancy due to unstable refractive changes;
- ✓ Plastic photochromatic lenses;
- ✓ Glass lenses of prescription power plus or minus 8 diopters;
- ✓ Varilux or other progressive addition-type multifocals, including blended bifocals; or
- ✓ Sunglasses.

Contact Lenses

How often does MAA cover contact lenses?

MAA covers contact lens replacements only once every 12 months.

What is covered?

MAA covers the following contact lenses:

1. **Gas permeable or daily wear soft contact lenses** as the client's primary refractive correction method if a client has a vision correction of plus or minus 6.0 diopters. (Use ICD-9-CM codes 367.0 or 367.1.)
2. **Therapeutic contact bandage lenses** only when needed immediately after either of the following:
 - Eye injury (ICD-9-CM codes 871-871.9); or
 - Eye surgery (CPT codes 65091-67599, 68020-68399).



Note: MAA does not cover contact lenses if the client's ocular condition makes it inadvisable for the client to use contact lenses.

(CPT codes and descriptions are copyright the American Medical Association.)

3. **Lenticular, aspheric, and myodisc contact lenses** when the client has one or more of the following:

- Multiple cataract surgeries on the same eye;
- Aphakia;
- Keratoconus with refractive error of plus or minus 10 diopters; or
- Corneal softening (e.g., bullous keratopathy).

Medical Problems	ICD-9-CM Diagnosis Codes
Aphakia	379.31 743.35
Keratoconus	371.6-371.62 743.41
Multiple cataract surgeries on the same eye (12-month limit does not apply)	366.0-366.09 366.17-366.9
Corneal softening, such as caused by Bullous Keratopathy	371.23

4. **Soft toric contact lenses** (daily wear) for clients with astigmatism requiring a vision correction of plus or minus one diopter. They must also meet the vision requirement listed in #1. (Use ICD-9-CM codes 367.20, 367.21, or 367.22 for astigmatism.)

Replacements

MAA covers the replacement of contacts within one year of the last dispense when contacts are broken or lost and **both** of the following are documented in the client's record:

- Copy of current prescription (must not be older than 17 months); and
- Date of last dispense documented.



Note: For billing, see Section I – Authorization.

What is not covered?

- ✓ Contact lenses for a client who has received MAA-covered eyeglasses within the past 2 years, unless the provider can document the medical necessity to MAA's satisfaction;
- ✓ Disposable contact lenses; or
- ✓ Contact lenses upgraded at private expense to avoid MAA's contract limitations.

Billing for Fitting Fees

Please use the following state-unique procedure codes when billing MAA for fitting fees for contact lenses.

Payable to Ophthalmologists, Optometrists, and Opticians.

State-Unique Procedure Code	Description	Maximum Allowable Fee Non-Facility/Facility Setting Effective 7/1/02
9275M	Fitting fee including dispensing for therapeutic bandage lenses. (This includes 14-day follow-up care.)	\$123.53
9276M	Fitting fee including dispensing for contact lenses. (This includes 30-day follow-up care for the training period.)	46.33
9277M	Fitting fee including dispensing of contact lenses for treatment for disease. (This includes 90-day follow-up care.)	140.75

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Ocular Prosthetics

Not payable to Opticians.

When does MAA cover ocular prosthetics?

MAA covers ocular prosthetics when they are medically necessary and provided by any of the following enrolled/contracted providers:

- An Ophthalmologist;
- An Ocularist; or
- An Optometrist who specializes in orthotics.

Billing

Procedure Codes: Refer to MAA's Physician-Related Services Billing Instructions for a complete listing of CPT codes and maximum allowables or go to: <http://maa.dshs.wa.gov>, click on Provider Publications/Fee Schedules.

HCPCS Procedure Codes: Please use one of the following HCPCS procedure codes when billing for Ocular Prosthesis.

Not payable to Opticians

HCPCS Code	Description	Effective 7/1/03
		Maximum Allowable
V2623	Prosthetic, eye, plastic, custom	\$862.80
V2624	Polishing/resurfacing of ocular prosthesis	65.09
V2625	Enlargement of ocular prosthesis	395.77
V2626	Reduction of ocular prosthesis	213.33
V2627	Scleral cover shell	1,377.82
V2628	Fabrication and fitting of ocular conformer	325.33
V2630	Anterior chamber intraocular lens	342.42
V2631	Iris, supported intraocular lens	342.42
V2632	Posterior chamber intraocular lens	342.42

(CPT codes and descriptions are copyright 2002 American Medical Association)

Cataract Surgeries

This information is for referral purposes only.

When does MAA cover cataract surgery?

MAA covers cataract surgery when it is medically necessary and the provider clearly documents the need in the client's file.

MAA considers the surgery medically necessary when the client has either of the following:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- One or more of the following conditions:
 - ✓ Dislocated or subluxated lens;
 - ✓ Intraocular foreign body;
 - ✓ Ocular trauma;
 - ✓ Phacogenic glaucoma;
 - ✓ Phacogenic uveitis; or
 - ✓ Phacoanaphylactic endophthalmitis.

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(Revised July 2003)

Memo 03-32 MAA

- H.2 -

**Ocular Prosthetics/
Cataracts Surgeries**

Authorization


(Ophthalmologists, Optometrists, Opticians)

What is prior authorization?

Prior authorization is MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

What are Limitation Extensions?

Limitation extensions are cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administration Code (WAC).

 **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

For example: Eyeglasses are not covered under the Family Planning Only Program.

How do I request a limitation extension?

There are two ways to request a limitation extension:

- 1) Providers may be able to obtain authorization for these limitation extensions using an expedited prior authorization number. These EPA numbers will be subject to post payment review as in any other authorization process. (See “What is expedited prior authorization,” page I.3.)
- 2) In cases where the client’s situation does not meet the EPA criteria for a limitation extension, but the provider still feels that additional services are medically necessary, the provider must request MAA-approval in writing.

The request must state the following in writing:

1. The name and PIC number of the client;
2. The provider’s name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date of last dispense;
5. The primary diagnosis code and CPT code or state assigned code;
and
6. Client-specific clinical justification for additional services.

Send your written request for a limitation extension to:

Division of Health Services Quality Support
Quality Fee for Service Section
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Telephone: (360) 725-1583
Fax (360) 586-2262

What is expedited prior authorization (EPA)?

EPA numbers are designed to eliminate the need for written authorization. MAA establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **form a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages I.4 and I.5 for codes). Enter the EPA number on the billing form in *field 23*, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for an exam for a client who has had an exam 20 months ago but now has lost his or her glasses, would be **870000610**

870000 = first six digits of all expedited prior authorization numbers;

610 = last three digits of an EPA number indicating the service and which criteria the case meets

- MAA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.
- The billing provider must document in the client's file how the expedited prior authorization criteria was met, and make this information available to MAA on request.

**Expedited Prior Authorization
Criteria Coding List on next page** 

**Washington State
Expedited Prior Authorization Criteria Coding List**

Code	Criteria	Code	Criteria
Visual Exams (Optometrists/Ophthalmologists Only) CPT: 92014-92015		619 <u>Durable Frames</u> when <u>one</u> of the following is documented in the client's record: <ol style="list-style-type: none"> 1) The client is diagnosed with a seizure disorder that results in frequent falls; <u>or</u> 2) The client has a medical condition that has resulted in two or more broken eyeglass frames in a 12-month period. 	
610 <u>Eye Exam</u> within two (2) years of last exam when no medical indication exists and both of the following are documented in the client's record: <ol style="list-style-type: none"> 1) Glasses or contacts are broken or lost; <u>and</u> 2) Last exam was 18 months ago or longer. 		620 <u>Flexible Frame</u> when <u>one</u> of the following is documented in the client's record: <ol style="list-style-type: none"> 3) The client is diagnosed with a seizure disorder that results in frequent falls; <u>or</u> 4) The client has a medical condition that has resulted in two or more broken eyeglass frames in a 12-month period. 	
Dispensing\Fitting Fees For Glasses CPT: 92340-92342		Dispensing\Fitting Fees For Lenses Only CPT: 92341, 94342	
615 <u>Glasses (both frames and lenses)</u> within two (2) years of last dispense may be replaced when glasses are broken or lost and <u>all</u> of the following are documented in the client's record: <ol style="list-style-type: none"> 1) Copy of current prescription (must not be older than 17 months); <u>and</u> 2) Date of last dispense; <u>and</u> 3) Both frames and lenses are broken or lost. 		623 <u>Lenses Only</u> within two (2) years of last dispense when the lenses only are lost or broken and <u>all</u> of the following are documented in the client's record: <ol style="list-style-type: none"> 1) Copy of current prescription (prescription must not be older than 17 months); <u>and</u> 2) Date of last dispense; <u>and</u> 3) Documentation of lens damage or loss. 	
Dispensing\Fitting Fees For Frames Only CPT: 92340			
618 <u>Frames Only</u> within two (2) years of last dispense may be replaced when frames only are broken, and all of the following are documented in the client's record: <ol style="list-style-type: none"> 1) No longer covered under the manufacturer's one (1) year warranty; <u>and</u> 2) Copy of current prescription demonstrating the need for prescription eye wear; <u>and</u> 3) Documentation of frame damage. 			

(CPT codes and descriptions are copyright the American Medical Association.)

Code	Criteria	Code	Criteria
624	<p><u>Lenses Only</u> within two (2) years of last dispense, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lenses at no charge) when <u>all</u> of the following are documented in the client's record:</p> <ol style="list-style-type: none"> 1) Copy of current prescription (prescription must not be older than 17 months); <u>and</u> 2) Date of last dispense; <u>and</u> 3) The current exam shows a refractive change of .75 diopters or more; <u>and</u> 4) The client has headaches, blurred vision, difficulty with school or work and it has been diagnosed by a physician as caused from the inability to see adequately; <u>and</u> 5) The client does not have a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy). <p>Note: In conditions other than pregnancy, if vision has been stable for 3 months and medical condition is stable, lenses are allowed when (1)-(4) previously listed are true.</p>	<p><u>Dispensing/Fitting Fees For Contacts</u> State-Unique Codes: 9275M, 9276M, or 9277M</p>	<p>627 <u>Contacts (client must meet criteria listed in Section G – Contact Lenses)</u> within one (1) year of last dispense may be replaced when contacts are broken or lost and <u>both</u> of the following are documented in the client's record:</p> <ol style="list-style-type: none"> 1) Copy of current prescription (must not be older than 17 months); <u>and</u> 2) Date of last dispense documented.
625	<p><u>High Index Lenses</u> when <u>one</u> of the following is documented in the client's record:</p> <ol style="list-style-type: none"> 1) Spherical correction is greater than, or equal to, +/- 8 diopters; <u>or</u> 2) Cylinder correction is greater than, or equal, to +/- 3 diopters. 		
626	<p><u>Executive bifocals and trifocals</u> for clients 11 years of age and older, with a diagnosis of accommodative esotropia or strabismus documented in the client's record.</p>		

(CPT codes and descriptions are copyright the American Medical Association.)

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Where and How Do I Order?

Who is MAA's eyeglass contractor?

MAA's eyeglass contractor is Airway Optical (Washington State Department of Correctional Industries).

Eyeglasses and contact lenses, including therapeutic soft contact (bandage) lenses, are covered for eligible Medical Assistance clients only through Airway Optical. No other optical manufacturer or provider will be reimbursed for frames, lenses, or contact lenses.

Send or fax completed prescriptions and/or purchase orders for sample kits, eyeglass frames, lenses, and contact lenses to:

Airway Optical

11919 West Sprague Avenue
PO Box 1959
Airway Heights, WA 99001-1959
Customer Service: 1-888-606-7788
Fax: 1-888-606-7789

Send order to:

General Ordering Information

- **Airway Optical will supply prescription order forms upon request.**
Please call Airway Optical's toll-free number at (888) 606-7788 to order additional forms.
- All prescriptions must be legible and include the prescribing provider's name, return address. The eyeglasses will be mailed to the provider by Airway Optical.
- Providers must mail eyeglass orders, along with a copy of the client's Medical Assistance IDentification (MAID) card, to the contractor. Orders and MAIDs may also be faxed. The copy of the MAID must be legible. Keep a copy of the order on file, along with the verification of the fax order.
- DSHS requires Airway Optical to process prescriptions within 10 working days, including shipping and handling time, after receipt of a properly completed order. MAA allows 20 days for completing special orders. Airway Optical must notify the provider when a prescription cannot be processed within either of these specified delivery timeframes.
- Include the appropriate diagnosis code on all order forms for eyeglass and contact lenses. If the appropriate diagnosis code is not included on the form, the contractor is required to reject and return the order.
- The contractor will reject and return an order for an eligible client for whom MAA has already purchased a pair of lenses and/or complete frame within the applicable benefit period (12 or 24 months, as appropriate). Similarly, the contractor will reject an order for contact lenses for an eligible client if MAA has already paid for contact lenses or eyeglasses for that client within the past 12 months.
- To obtain general information, or to inquire about overdue prescriptions, call the contractor at their toll-free number.

Airway Optical

USE ONLY FOR WASHINGTON STATE
MEDICAID SERVICES

PROVIDER NAME AND ADDRESS

Tray #

Date Ordered:

SPHERE	CYLINDER	AXIS	PRISM	BASE	DECENTRATION
R					
L					
ADD POWER	HEIGHT	WIDTH	INSET	TOTAL INSET	PUPILLARY WIDTH DISTANCE
R					NEAR
L					
Single Vision	Flat Top	Round	7X28 Trifocal	Other	Safety
Glass <input type="checkbox"/>	Plastic <input type="checkbox"/>	Other <input type="checkbox"/>	Scratch Coat <input type="checkbox"/>	Tint <input type="checkbox"/>	
Frame Home	Eye Size	DBL	Temple Length	Temple Type	Circ.
Frame Color					

SPECIAL INSTRUCTIONS

ALL ITEMS IN THIS SECTION MUST BE FILLED OUT COMPLETELY

PATIENT NAME

(LAST, FIRST, M.I.)

PIC NO.

ICD-9 DX CODE

PRIOR AUTHORIZATION #

PROVIDER #

Provider's County

FAX TO:

MEDICAL RECORD #

438499

Airway Optical

Fax: 1-888-606-7789

Call Toll Free: 1-888-607-7788

Final Insp.

Drop Ball

Eligibility Verification

This Is A Numerically Controlled Form.

USE ONLY ONCE

FOR FAX USE ONLY

A COPY OF THE
CLIENT'S DSHS COUPON
MUST BE ATTACHED HERE

Sample

Airway Optical				PROVIDER NAME AND ADDRESS			
USE ONLY FOR WASHINGTON STATE MEDICAID SERVICES							
Tray #		Date Ordered:					
	SPHERE	CYLINDER	AXIS	PRISM	BASE	DECENTRATION	
R							
L							
	ADD POWER	HEIGHT	WIDTH	INSET	TOTAL INSET	PUPILLARY WIDTH	
R						DISTANCE	NEAR
L							
Single Vision		Flat Top	Round	7X28 Trifocal		Other	
						Safety	
Glass <input type="checkbox"/>		Plastic <input type="checkbox"/>		Other <input type="checkbox"/>		Scratch Coat <input type="checkbox"/> Tint <input type="checkbox"/>	
Frame Name			Eye Size	DBL	Temple Length	Temple Type	Circ.
Frame Color							
SPECIAL INSTRUCTIONS							
ALL ITEMS IN THIS SECTION MUST BE FILLED OUT COMPLETELY							
PATIENT NAME (LAST, FIRST, M.I.)							
PIC NO.							
ICD-9 DX CODE				PRIOR AUTHORIZATION #			
PROVIDER #				Provider's County			
Airway Optical Correctional Industries 11919 W. Sprague Ave. P.O. Box 1959 Airway Heights, WA 99001-1959 Call Toll Free: 1-888-606-7788 Or At Fax: 1-888-606-7789				MEDICAL RECORD # 407749			
Final Insp.		Drop Ball		Eligibility Verification			
This Is A Numerically Controlled Form.							
USE ONLY ONCE							

Sample

Fee Schedule

(Ophthalmologists/Optometrists/Opticians)

Due to its licensing agreement with the American Medical Associations, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

7/1/03			
Maximum Allowable Fee			
CPT Procedure Code	Brief Description	Non-Facility Setting (NFS)	Facility Setting (FS)
0311M*	Operating costs in nursing homes. (Allowed once per visit, per facility, regardless of how many clients are seen, <u>when</u> eyeglass fitting or eligible repair services are performed.)	\$17.01	\$17.01
Billable by Opticians Only			
Fitting fees are <u>not</u> covered by Medicare and may be billed directly to the MAA without attaching a Medicare denial.			
92340	Fitting of spectacles	24.80	24.80
92341	Fitting of spectacles	27.98	27.98
92342	Fitting of spectacles	29.80	29.80
92352	Special spectacles fitting	24.80	24.80
92353	Special spectacles fitting	29.12	29.12
92354	Special spectacles fitting	204.30	204.30
92370	Repair & adjust spectacles	20.48	20.48
92371	Repair & adjust spectacles	14.56	14.56
9274M*	Materials for eyeglasses repair	15.17	15.17
9275M*	Fitting fee for therapeutic bandage lenses. (This includes 14-day follow-up care and dispensing)	123.53	123.53
9276M*	Fitting fee for contact lenses. (This includes 30-day follow-up care for the training period and includes dispensing.)	46.33	46.33


*State-Unique Code

(CPT codes and descriptions are copyright 2001 American Medical Association.)

Vision Care

7/1/03 Maximum Allowable Fee			
CPT Procedure Code	Short Description	Non-Facility Setting (NFS)	Facility Setting (FS)
9277M*	Fitting of contact lenses for treatment of disease. (This includes 90-day follow-up care and includes dispensing.)	\$140.75	\$140.75
92499	Eye service or procedure	B.R.	B.R.

*State-Unique Code

 **NOTE:** MAA does not separately reimburse a nursing facility for eye exams, refractions, and fitting and repairing of eyeglasses when provided by optometrists and opticians using their own equipment. The criteria used for reimbursing providers at NFS maximum allowable fee is when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

(CPT codes and descriptions are copyright 2001 American Medical Association.)

General Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

- ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders MAA to cover the services; or
 - The date DSHS certifies a client eligible under delayed¹ certification criteria.



Note: If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

- ✓ **MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:**
 - DSHS certification of a client for a retroactive² period; or
 - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

¹ **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

² **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

- ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. Please refer to the client's MAID card for the PCCM.

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

What records must be kept? [WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications, equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ X-rays, tests, and results;
 - ✓ Dental photographs/teeth models;
 - ✓ Plan of treatment and/or care, and outcome; and
 - ✓ Specific claims and payments received for services.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

How do I bill for clients who are eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance (otherwise known as “dual-eligible”), **you must first submit a claim to Medicare and accept assignment within Medicare’s time limitations.** MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA’s initial 365-day requirement for initial claims (see page L.1).

Specific Information to Vision Care

- Medicare will furnish one pair of contact lenses or eyeglasses following each cataract surgery for aphakic patients. If the patient is a client of both Medicare and Medical Assistance, **MAA will cover services and eye wear which are not covered by Medicare.**
- Eye examinations for dual-eligible clients must be billed directly to Medicare first.
- Refractions and fitting fees for dual-eligible clients must be billed directly to MAA. Medicare does not cover these services.

If Medicare denies a service as noncovered, or the client is not eligible for Medicare Part B, submit the claim to MAA on the HCFA-1500 claim form with the Medicare denial (EOMB) attached.

MAA must receive claims for dual-eligible clients MAA within six (6) months of the Medicare EOMB statement date. The 365-day billing period does not apply in this case.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.
- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.
- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

 **Note:**

- ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

- 1) The provider accepts assignment; and
- 2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. Insured's ID No.: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the MAID card consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
 - John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B
- 2. Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).
- 3. Patient's Birthdate:** Required. Enter the birthdate of the MAA client.

4. Insured's Name (Last Name, First

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

- 5. Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

- 9. Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance).

10. Is Patient's Condition Related To:

Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:

Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. Insured's Date of Birth:

Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. Employer's Name or

School Name: Primary insurance. When applicable, enter the insured's employer's name or school name.

- | | |
|--|---|
| <p>11c. <u>Insurance Plan Name or Program Name:</u> Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. <i>(Note: This may or may not be associated with a group plan.)</i></p> <p>11d. <u>Is There Another Health Benefit Plan?:</u> Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i>. If yes, you should have completed <i>fields 9a.-d.</i> If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i>. If 11d. is left blank, the claim may be processed and denied in error.</p> <p>17. <u>Name of Referring Physician or Other Source:</u> When applicable, enter the referring physician or Primary Care Case Manager name.</p> <p>17a. <u>ID Number of Referring Physician:</u> When applicable, 1) enter the 7-digit MAA-assigned primary physician number; or 2) when the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCm plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.</p> | <p>19. <u>Reserved For Local Use:</u> When applicable, enter indicator B to indicate "Baby on Parent's PIC." Please specify twin A or B, triplet A, B, or C here.</p> <p>21. <u>Diagnosis or Nature of Illness or Injury:</u> When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.</p> <p>22. <u>Medicaid Resubmission:</u> When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the <i>Remittance and Status Report</i>.)</p> <p>23. <u>Prior Authorization Number:</u> When applicable. If the service or equipment you are billed for requires authorization, enter the 9-digit number assigned to you. Only one authorization number is allowed per claim.</p> <p>24. <u>Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.</u></p> <p>24A. <u>Date(s) of Service:</u> Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 04, 2000 = 090400).</p> |
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Vision Care

24B. Place of Service: Required. Enter the appropriate code as follows:

Code Number	To Be <u>Used For</u>
------------------------	----------------------------------

3	Office or ambulatory surgery center
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)

24C. Type of Service: Required.
Optometrists - enter a 3.
Opticians - enter a 9.

24D. Procedures, Services or Supplies CPT/HCPCS: Required. Enter the appropriate procedure code for the service(s) being billed.

24E. Diagnosis Code: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. \$ Charges: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. Days or Units: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. Federal Tax ID Number: Leave this field blank.

26. Your Patient's Account No.: Not

required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. Total Charge: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. Amount Paid: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. Balance Due: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. Physician's, Supplier's Billing Name, Address, Zip Code And Phone #: Required. Put the *Name, Address* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

- A. An individual practitioner (solo practice); **or**
- B. An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the

entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)			MEDICAID <input type="checkbox"/> (Medicaid #)			CHAMPUS <input type="checkbox"/> (Sponsor's SSN)			CHAMPVA <input type="checkbox"/> (VA File #)			GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>			FECA BLK LUNG (SSN) <input type="checkbox"/>			OTHER (ID) <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY M F						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																	
CITY						STATE						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						CITY						STATE											
ZIP CODE						TELEPHONE (Include Area Code) ()						Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>						ZIP CODE						TELEPHONE (INCLUDE AREA CODE) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F						c. EMPLOYER'S NAME OR SCHOOL NAME						d. INSURANCE PLAN NAME OR PROGRAM NAME											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE												17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____												23. PRIOR AUTHORIZATION NUMBER																							
24. A DATE(S) OF SERVICE. From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																			
1																																			
2																																			
3																																			
4																																			
5																																			
6																																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						28. \$ TOTAL CHARGE						29. \$ AMOUNT PAID						30. \$ BALANCE DUE					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____																	